1. Corporate Information

ValueOptions, Inc.
240 Corporate Blvd.
Norfolk, VA 23502
757-459-5200
757-892-5729

2. If a subsidiary or affiliate of a parent organization, corporate information of parent organization

FHC Health Systems, Inc.
240 Corporate Blvd.
Norfolk, VA 23502
757-459-5100

3. State of incorporation or where otherwise organized to do business

ValueOptions, Inc. is incorporated in the Commonwealth of Virginia. ValueOptions is licensed in most states.

4. States where currently licensed to accept risk and a description of each license.

We provide a chart with states where we are currently licensed to accept risk and a description of the licenses below.

Licensing Agency	State	License Type	License #
State Corporation Commission	VA	FHC Options – Certificate of Authority	47003
Department of Health	PA	PPO Value Behavioral Health	
Department of Insurance	AZ	Wellington COA	E146
Department of Corporations	CA	ValueOptions of California COA	933-0293
Department of Insurance	TX	ValueOptions of Texas COA	12520
Department of Insurance	FL	Florida Health Partners COA	99-59-3537092
Department of Insurance	AZ	Wellington COA	017722
Department of Insurance	AR	Wellington COA	2137
Department of Insurance	CA	Wellington COA	
Department of Regulatory	CO	Wellington COA	2211

Licensing Agency	State	License Type	License #
Agencies – Insurance Division			
Department of Insurance	DE	Wellington COA	2173
Department of Insurance & Securities Regulation	DC	Wellington COA	85537
Office of Insurance & Safety Fire Commissioner	GA	Wellington COA	2000657
Department of Commerce & Consumer Affairs – Insurance Division	HI	Wellington COA	100771
Department of Insurance	ID	Wellington COA	1634
Department of Insurance	IN	Wellington COA	
Department of Insurance	IA	Wellington COA	2261
Department of Insurance	KS	Wellington COA	
Department of Insurance	LA	Wellington COA	
Maryland Insurance Administration	MD	Wellington COA	001516
Department of Insurance	MS	Wellington COA	8300008
Department of Insurance	MT	Wellington COA	2161
Department of Insurance	NE	Wellington COA	79870
Department of Commerce – Insurance Division	NV	Wellington COA	3070
Department of Insurance	NM	Wellington COA	4168
Department of Insurance	NC	Wellington COA	04-2741
Department of Insurance	ND	Wellington COA	
Department of Insurance	OH	Wellington COA	85537
Department of Insurance	OK	Wellington COA	8694
Department of Insurance	OR	Wellington COA	2633
Department of Insurance	PA	Wellington COA	85537
Department of Insurance	SC	Wellington COA	AUR-131
Department of Insurance	SD	Wellington COA	01659
Department of Insurance	TX	Wellington COA	7589
Department of Insurance	UT	Wellington COA	83919
Department of Insurance	WA	Wellington COA	1624
Department of Insurance	WI	Wellington COA	000-85537

5. Contact Information

Candice W. Nardini, MPA
Chief Development Officer
515-287-5785
515-988-9082 (cell)
515-287-5864
candice.nardini@valueoptions.com

6. Program Experience – General

ValueOptions was founded almost two decades ago and currently serves more than 23 million people through public and private sector contracts in all 50 states. We currently maintain more than 800 contracts ranging in size from small Employee Assistance Programs covering 40 employees to large Medicaid contracts covering more than one million members. ValueOptions has a nationwide network of more than 50,000 practitioners and facilities in 95,000 provider locations. To best serve the array of entities with whom we contract, ValueOptions is divided into four major divisions: public sector, federal, health plan, and employer groups.

Our Public Sector Division has contracts with some 50 counties and state agencies to oversee the provision of behavioral health care funded through Medicaid and other public funding streams.

A. Do you have at least three years Medicaid experience under capitation? If yes, please identify the states and contract periods. If not do you have at least three years of experience under capitation in another market?

Yes. ValueOptions has been providing managed behavioral health care services for Medicaid recipients since 1994. Our Public Sector Division (PSD) currently has 17 contracts executed directly with states or counties that operate in a capitated environment. Our Health Plan Division also serves Medicaid recipients through sub-contractual relationships with health plans, many of which are sub-capitated. Please see the chart on the following page for a list of contracts currently operated through our Public Sector Division.

ValueOptions Public Sector Business

The following table abstracts a selection of ValueOptions' current risk-bearing, capitated public sector contracts.

Location	Type of Contract	Covered Lives	Year Started	Unique Features/ Accomplishments
Arizona (Maricopa County, metro Phoenix)	Risk	240,000	1999	Contract features 18 blended funding streams to create an integrated system of care, which includes providing and managing supportive housing for almost 5,000 individuals with mental illness.
Colorado (40 counties)	Risk shared with Partners	87,000	1995	50-50 partnership with community mental health centers; won national recognition for its recovery model.
Florida (five counties, metro Tampa)	Risk shared with Partners	56,000	1996	Received national award of excellence for being an effective, efficient provider organization.
Massachusetts – Massachusetts Behavioral Health Partnership	Risk Corridor	332,000	1996	Performance-based contracting; includes network management services for a primary care clinician network of almost 400 providers.
New Mexico	Risk and ASO	320,000	2005	Integrated contract executed with 17 agencies that fund services or supports for people who receive behavioral health treatment; Medicaid, child welfare, corrections, mental health and substance abuse block grants and various other state and federal funding streams
Pennsylvania (9 counties)	Risk and Shared Risk	151,000	1999	Program is customized to meet the unique needs of each individual county.
Texas (Dallas County)	Risk	550,000	1999	Finalist for Harvard's Innovation in American Government Award (2002).

States with whom ValueOptions holds non-risk contracts include:

- Connecticut,
- New Jersey,
- more than 30 California counties, and
- North Carolina.

B. Are you currently accredited by NCQA for your Medicaid product line? If no, are your or any other plans operated by your parent or affiliate NCQA accredited? Which product lines? Would you be willing to become NCQA accredited within a reasonable period of time after contract award? Do you have experience with HEDIS and CAHPS? Please explain.

ValueOptions is not currently accredited by NCQA for our Medicaid product line. ValueOptions holds NCQA accreditation for two of our service centers: Great Lakes and Northeast for commercial and health plan products. ValueOptions does have URAC accreditation for 14 service centers.

C. Do you currently contract with any State to provide Medicaid services? If yes, proceed to question 7. If not proceed to question 10.

Yes. ValueOptions PSD has contracts in 11 states to provide Medicaid services.

7. Medicaid Program Experience – Services

Every public sector program operated by ValueOptions is different because ValueOptions customizes its approach to support the vision behind each program and the unique characteristics of each delivery system. As indicated on the chart above, ValueOptions has experience providing managed behavioral health care services for Medicaid recipients. Services provided through these contracts include:

- Quality Management,
- Utilization Management,
- Care Management,
- Disease Management,
- Coordination with and/or management of physical health services,
- Enrollment assistance,
- Member Services,
- Member Grievances and Appeals,
- Network Management including Provider Credentialing,
- Pharmacy Benefits, and
- Claims Processing and Adjudication.

8. Medicaid Program Experience – Population

We provide the populations served by our public sector contracts in the chart above. In several contracts held by the Public Sector Division, ValueOptions serves Medicaid beneficiaries as well as enrollees who are served through other state and federally funded programs.

9. Medicaid Program Experience – Payment Methodology

ValueOptions' Public Sector Division has experience in a variety of payment arrangements with the states and counties with whom we contract. As indicated in the chart on *page 4* above, we have payment arrangements in which ValueOptions has:

- full risk for all covered services,
- limited risk, generally around a negotiated risk target which includes a risk corridor for financial loss and profit,
- entered into a full partnership with providers, such as in Colorado and Florida, and shares risk based on the partnership agreement, and
- responsibility for administrative services only (ASO).

ValueOptions' contracts with Massachusetts and Connecticut both provide for additional payments when our performance meets or exceeds negotiated benchmarks or when targeted programs or initiatives are completed. The contract terms are lengthy, but copies can be provided at the request of the Bureau of TennCare.

10. Experience – Former Medicaid and/or Commercial

ValueOptions has current Medicaid experience.

11. Reformed Managed Care Model

A. Behavioral Health

1. Is your organization currently responsible for providing behavioral health services? If yes, in what state Medicaid programs? Please describe the services you provide and to what populations. Please specify if you serve individuals with serious emotional disturbance (SED) and/or individuals with severe persistent mental illness (SPMI). Please also specify whether you provide these services directly or whether you use a subcontracted arrangement. If a subcontract arrangement is used, please fully describe such arrangements and how coordination across entities is ensured. How/who handles member/provider services, appeals, claims, etc. How is the subcontractor paid?

ValueOptions Public Sector Division currently provides managed behavioral health care services in 11 states (please see chart on *page 4*, above). In most contracts, ValueOptions manages the delivery of services to Medicaid beneficiaries in all eligibility categories. In many contracts, we also serve people whose services are funded through federal block grants and other state and federal funds. Children who are receiving child welfare services, especially those who are living in out-of-home placements also are frequently among the enrollees we are contracted to serve. In other words, we have experience serving the children

and families who are eligible based on programs such as Temporary Assistance to Needy Families (TANF) as well as people who are eligible based on a disability determination.

As our approach to serving adults, children and families in publicly funded programs has grown, ValueOptions has come to understand the importance of identifying and focusing on consumers who have the greatest need for treatment and also on consumers who are most at risk of requiring intensive mental health services. Certainly these high need and at-risk consumers are all ages. Although they are relatively few in number, their services often account for more than 80 percent of all expenditures and an even higher proportion of admissions to 24-hour treatment settings.

Although Maricopa County is the only program in which ValueOptions actually employs case managers to serve high need members, the same general approach to high need members is mirrored in most other ValueOptions public sector programs. In almost every public sector program, we employ both Care Managers and Intensive Care Managers, who are located in our Service Center, as well as Regional Care Managers, who work directly with providers to provide additional support t to both consumers and providers who can most benefit from additional clinical support and supervision. These Care Managers are paid as part of our administrative budget, not from funds earmarked for direct clinical service provision (the medical budget).

For all our programs, including Maricopa County, ValueOptions relies on a contracted provider network to provide the direct treatment services. However, as a company that specializes in behavioral health care programs, we do not sub-contract management responsibilities to other organizations except in relationships such as the Colorado and Florida provider partnerships.

2. ***Please describe your medical management model for care coordination and services integration between behavioral health providers and physical health providers, in particular an individual's primary care provider. Please describe your experience with ethnically and racially diverse populations in physical health and behavioral health settings.***

Coordination of Care with Primary Care Providers (PCPs)

ValueOptions certainly recognizes the importance of coordination between behavioral health and physical health providers, and we have a variety of strategies to encourage the on-going communication between all providers of health care serving an individual consumer. These include, but are not limited to:

- as part of our provider contracts, establishing policies and procedures for requesting the consumer's approval to share information with the consumer's primary care physician and auditing records to verify compliance;
- leveraging technology to support the exchange of information, such as establishing dedicated web portals and secure e-mail linkages;

- providing consumer-specific and prescriber-specific profiles to primary care physicians reflecting our analysis of the utilization of psychotropic medications;
- offering training to non-psychiatric physicians and requesting training from HMOs and other organizations closely linked to providers of physical health care; and
- using Peer Specialists, providers and others to help educate consumers about the importance of (1) regular visits to their PCP and (2) updating their PCP about their behavioral health treatment and medications.

Perhaps most importantly, ValueOptions reaches out to the health plans who also serve our members and establishes protocols for providing joint/integrated care management for consumers with acute or chronic treatment needs for both physical and behavioral health care. In general, this coordination is the responsibility of ValueOptions' Care Managers and Intensive Care Managers. The coordination with managed care organizations (MCOs) frequently includes developing and implementing shared or concurrent quality improvement initiatives as well.

The Massachusetts Behavioral Health Partnership has contractual responsibility to monitor services provided by PCPs, and has developed many effective strategies for collaborating with primary care physicians. These strategies have been expanded to also support effective interfaces with the managed care organizations that also serve our members, such as:

- designating one of the Clinical Department supervisors as the key liaison and point of contact with the MCOs and PCPs;
- determining which information is most important to MCOs and PCPs and what is the most effective way in which to share that information;
- establishing regular meetings in which issues of coordination and communication can be discussed;
- sharing policies and procedures and developing effective referral strategies; and
- implementing collaborative quality management studies designed to determine best practices for coordinating care and assuring optimum treatment outcomes.

ValueOptions has developed a PCP interface policy and procedure that is the foundation for our approach to coordinating care between PCPs and behavioral health professionals, and is designed to support:

- better coordination of consumers' total health care needs,
- improved quality and outcome of treatment,
- reduced overall utilization of services,
- improved cost effectiveness, and
- prevention, management, and stabilization of long-term relapse-prone conditions.

Diverse Populations

ValueOptions is committed to cultural competency. We recognize cultural competency is demonstrated by an organization's capacity to respond well to diverse memberships' health-related beliefs and cultural values, variance in disease incidence and prevalence, and needs for different treatment modalities to ensure treatment efficacy. Core to these approaches is

the implementing of the Culturally and Linguistically Appropriate Services (CLAS) standards into our operations.

Cultural competency is a key concern in all our public sector contracts, especially in Arizona, Texas and New Mexico, where a rapidly increasing percent of our enrollees do not consider English as their primary language. Although the strategies in each program differ, some of the most successful include:

- using Peer Advocates with specific cultural backgrounds to work with members of the same backgrounds;
- developing training programs for providers and ValueOptions staff to help them explain and understand cultures in their local area; often these programs are designed with and presented by members of those communities; and
- hiring staff that represent the cultural profile of the region, and especially staff who are bilingual; in Arizona, staff are even paid at a higher hourly rate if they are determined to speak Spanish competently.

As an organization, ValueOptions has defined cultural competency in behavioral health care as the establishment of a workforce and services with:

- staff, knowledgeable of the native languages and backgrounds representative of the patient populations;
- sensitivity toward the cultural distinctions of customers and the ability to mobilize community resources when necessary for customer's treatment or advocacy;
- continual education and advocacy within conventional systems to ensure access to culturally competent services for customers;
- a community-based program fostered by the active participation of a strong community constituency;
- treatment modalities which reflect the cultural, ethnic, and sexual values and treatment requirements of the population; and
- inclusion of customers and families in decision making, policy implementation, and enforcement.

3. While the state believes that the proposed coordinated care approach will improve continuity of care broadly, TennCare is particularly concerned with maintaining the highest quality of care for those individuals on our program with SED and SPMI.

a. Please describe your experience with these populations including specific programs and interventions (e.g., early intervention, psychiatric rehabilitation and recovery).

As one of the nation's major public sector managed behavioral health care organizations, ValueOptions has had extensive experience in ensuring a high quality of behavioral health care for people with SPMI and children with SED. We have also

emphasized the ongoing coordination of behavioral health care with physical health care in all our public sector programs.

Massachusetts
In Massachusetts, ValueOptions has developed Essential Care, an integrated care program for high risk individuals. This program is designed to serve members:

- with complicated treatment plans,
- experiencing difficulty managing their physical illness,
- who frequently receive routine or primary care at hospital emergency departments,
- who fail to keep appointments for medical services, and
- who are not compliant with their medication regimen for a medical illness.

The program goals are to increase Member access to appropriate services and to improve the health status of participating Members. Each Member is assigned a care manager who coordinates the services of the primary care clinician, behavioral health providers, hospital emergency departments, specialists, state agencies, and community services.

Other States
ValueOptions' Public Sector Division is recognized nationally for its leadership in supporting states in implementing the philosophy of recovery and resiliency. Early identification of those who are at risk of becoming acutely or chronically disabled is a key component of the overall process. The concept of recovery and resiliency also promotes attention to all needs of the individual—including both physical and behavioral health care.

A few of the many innovative and effective initiatives that are part of ValueOptions' public sector programs include:

- ***Disease Management and Focused Case Management***. Arizona implemented specialized case management/community support services for consumers who have unique needs, including young adults with psychiatric disorders, people with co-occurring mental health and substance abuse disorders, customers with limited English proficiency, and pregnant women with substance abuse disorders.
- ***Comprehensive Assessments for Children***. In Pennsylvania, evaluators are trained and credentialed— and reimbursed at an enhanced rate— to provide comprehensive services that focus on identifying the needs of a child and family across areas of functioning, including physical health care, so those needs can subsequently be addressed in treatment
- ***Recovery Learning Centers***. Recovery Learning Centers are being piloted in Massachusetts. Learning Centers are a hub for consumers to learn about wellness— both physical and psychological— and to receive peer support and education. The Centers also promote self-help strategies.

ValueOptions is embracing the role of consumers and family members to a greater degree in each new contract. In both New Mexico and Connecticut, Peer Specialists— consumers and family members trained to offer support services— are employed by the Service Center and are an integral part of the overall operation of the program. We believe well-trained Peer Specialists are key in helping consumers, especially those with chronic conditions, understand and manage all facets of their illness.

b. What structural or contractual design choices would you recommend to ensure the needs of these populations are met?

Tennessee was one of the first states in the nation to recognize the uniqueness of the public behavioral health care delivery system. In recent years, many strides have been taken to strengthen that delivery system and provide a broader array of behavioral health care services and supports to Tennesseans. One goal of the Bureau of TennCare should be to maintain the progress already made and use it as a foundation for continuing to strengthen access to and the quality of publicly funded mental health and substance abuse services.

ValueOptions shares Tennessee's philosophy that meeting the needs of the most seriously ill must be a priority of every public sector delivery system. To ensure that appropriate services and supports continue to be available to these priority populations (such as people with chronic debilitating physical illnesses, medically fragile children, people with serious and persistent mental illness, people with co-occurring mental health and substance use issues, and children with SED), ValueOptions recommends that the Bureau of TennCare establish a reimbursement methodology that includes a percentage designated for the treatment of people in these disability categories. The percentage would be based on historical expenditures for these priority populations.

Another option would be for the Bureau of TennCare to create a Special Needs Plan that would be administered by organizations that could demonstrate experience in serving people who have special needs. In addition to serving those with chronic physical or behavioral health needs, the Special Needs Plan also could include those who are elderly, those who have physical or developmental disabilities, and those with ICF or ICF-MR levels of need but who are in waiver programs and community-based living arrangements. The contractor for such a Special Needs Plan could be responsible for both physical and behavioral health care treatment. An MCO or a BH-MCO (in a partnership or a sub-contractual arrangement that demonstrated the appropriate experience, financial stability and infrastructure) could be designated to manage the Special Needs Plan.

In this arrangement, a separate capitation rate(s) would be established for the Special Needs Plan. A contractual model that offers an actuarially established rate with a risk corridor to limit both potential financial loss and profit would be important to

contractors managing a Special Needs Plan. Performance standards and/or incentives to focus on mutually agreed upon clinical and administrative outcomes should also be an integral part of the design.

c. Would your interest level in bidding be positively or negatively impacted if the state were to consider excluding these individuals from this proposal?

If individuals with SPMI and SED were excluded, ValueOptions would probably focus on whatever opportunity the TennCare Bureau might offer related to serving people with serious and persistent illness and children with serious emotional disabilities.

d. Would your response to c. above change if the state were to adopt an alternative, more limited or no-risk arrangement for this population?

If people who have SPMI and SED are included, ValueOptions will be much more likely to respond to a Request for Proposals if there is a mechanism to ensure that adequate funds are available so the needs of these consumers can be adequately met.

If the Bureau adopts a design to serve people who are disabled by a broader array of conditions than solely SPMI and SED, ValueOptions recommends an incremental approach in which a limited or no-risk arrangement for priority populations be implemented until sufficient, accurate data is accumulated to allow actuaries to establish an actuarially sound capitation rate for the priority populations. The Special Needs contractor could then begin assuming additional financial risk.

4. Please describe your experience working with essential community providers such as community health clinics and community mental health agencies.

As an organization that specializes in serving people whose services are publicly funded, ValueOptions is highly experienced in working with essential community providers. For instance, in Florida and Colorado, community mental health centers are full partners with ValueOptions.

However, we begin every new public sector contract with an "every willing and qualified provider" approach and put a high priority on recruiting providers who are experienced in serving public sector consumers. In many cases, this includes contracting with federally qualified health centers and with large clinics, some of whom may not offer psychiatric services. However, to ensure access to medication management and medical oversight, our public sector Service Centers offer consultation by our Medical Directors and other psychiatrists to encourage non-psychiatric prescribers to support consumers in small communities and rural areas where psychiatric coverage is minimal or non-existent.

In some programs, ValueOptions also has supported community mental health centers and FQHCs or clinics to work cooperatively, often by locating a mental health professional in the medical setting. Telepsychiatry is another effective strategy some programs have used to link the accessibility of essential community providers such as community hospitals with psychiatric treatment and consultation.

5. ***Based on your experience coordinating physical and behavioral health services, do you have any specific recommendations regarding the design of the behavioral health proposal for TennCare? More specifically what financial guarantees, if any, might be necessary to ensure appropriate funding for these clinical services?***

Obviously one option still open to the TennCare Bureau is to continue to provide behavioral health care services through directly contracted specialty managed behavioral health care organizations. Many states choose this model as the most effective way to ensure behavioral health care services are appropriately provided. Most then ensure coordination with physical health care through a variety of penalties and incentives.

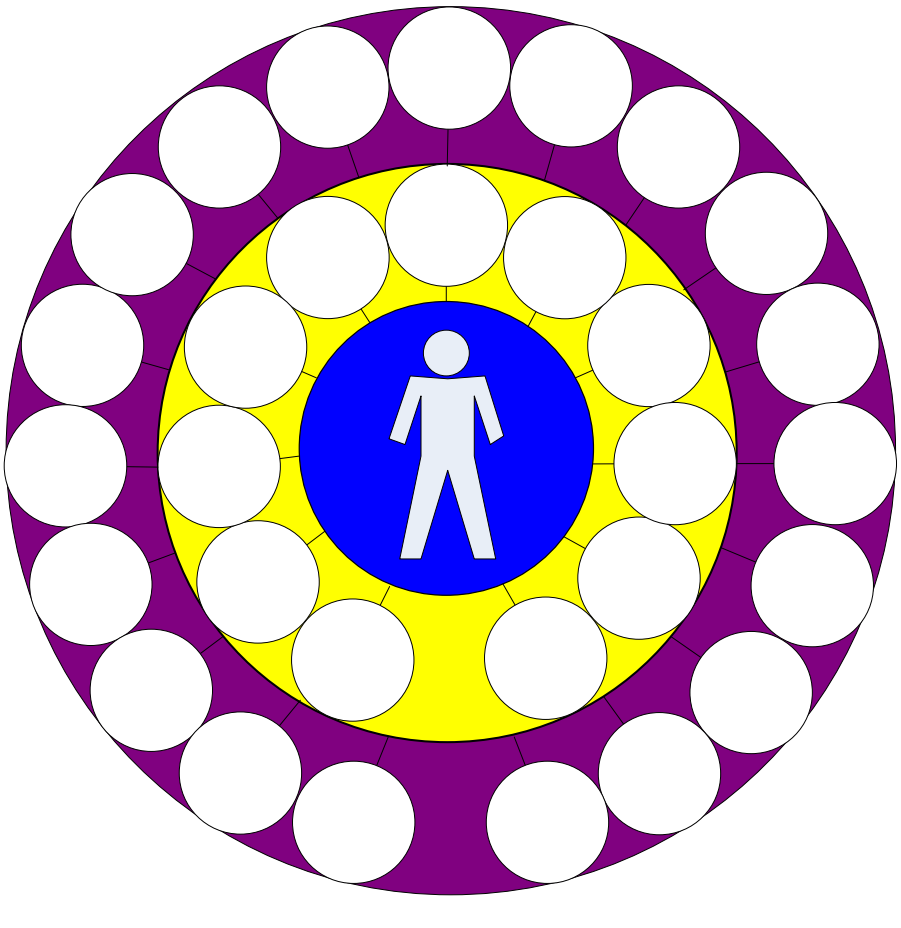
Another option is to adopt the multi-Departmental strategy that has been implemented in varying forms by states such as Arizona, the NorthSTAR program in Texas, New Mexico and Connecticut. In these designs, states have chosen to include funding and responsibility for a broad array of services and supports as a way of ensuring integration between multiple funding streams. The cost of physical health care has not been included in these programs, but all include mandated responsibilities on both behavioral and medical providers to ensure coordination for individual consumers and between managed care organizations.

The TennCare Framework

In this RFI, TennCare suggests a return to a model in which physical and behavioral health care are the responsibility of a single managed care entity. In this basic model, one of the greatest challenges is how to adequately serve those Medicaid beneficiaries whose services drive the largest percentage of overall program costs. These special populations include the aged, the blind and disabled, the Seriously and Persistently Mentally Ill, Seriously Emotionally Disturbed children, MR/DD members and the institutionalized living in long-term care or other state funded programs. Not only is the cost of care for these members exceptionally high, but these members also tend to pose the greatest risk in terms of adverse public relations and litigation. These populations tend to have poor overall health status and subsequently have a higher morbidity at earlier ages than the normal Medicaid population.

Many question whether a traditional managed care approach can adequately serve these members. If TennCare returns to a single vendor model, we believe these special populations should be enrolled into a fully integrated program. That program must be adequately funded and structured to allow the vendor to meet the unique needs each member and deliver those preventive, physical health, behavioral health and psycho-social services and supports that will allow the member live as independently as possible. This approach not only supports recovery and resiliency—it is also one of the most cost effective ways in which to serve people who have disabilities.

Tennessee could choose to blend this single vendor model with the integrated funding stream approach that has been implemented in other states. In such a fully integrated approach that encompasses a wide variety of funding streams in addition to Medicaid, the array of services are depicted in the graphic below.



Medicai

This model focuses on the unique needs of each Member. Based on the Member's specific needs, the Member's care manager coordinates the services of the primary care clinician, behavioral health providers, hospital emergency departments, specialists, state agencies and community services. The model is designed to ensure that the Member has improved access to the most appropriate services that will sustain and improve the Member's overall health status as documented by measurable outcomes (including outcome measures defined by members, and those that address clinical standards and economic expectations).

The array of services and the responsibility of the contractor could be adjusted based on the scope of the design adopted by TennCare. Expectations for coordination of services provided by excluded funding streams could be encouraged and/or required based on the level of administrative funding provided.

Child
Case
Integ

As indicated in the sections above, ValueOptions recommends that a historically-based proportion of the service dollars be allocated to providing behavioral health care services. In addition, we further recommend that consideration be given to allocating a historically-based proportion of service dollars to assuring the quality and accessibility of full health care services to people who have mental or physical disabilities.

We believe that services for people with the highest level of need are most effectively managed by managed care organizations with demonstrated experience in, and dedication to, working with people who have disabilities.

B. Pharmacy

ValueOptions has developed a data-driven approach to pharmacy management that has supported our full risk responsibilities for psychotropic medications in Arizona, Texas and New Mexico. Like our approach to Utilization Management, our pharmacy management focuses on identifying prescribers and consumers whose patterns fall outside recommended practice.

C. Long Term Care Services

Not applicable.

D. EPSDT Incentives

Not applicable.

E. Utilization Management/Medical Management

Not applicable

F. Disease Management

Behavioral Health

In addition, the following behavioral health conditions are targeted for care management interventions.

- ***Schizophrenia***
- ***Bipolar disorder***
- ***Major depression***

- ***Co-occurring mental illness/substance abuse***

ValueOptions has a strong and time-tested process for disseminating and encouraging the use of the latest evidence-based practices for targeted care management interventions. Through our corporate and Public Sector Clinical Advisory and QM Committees we have established and updated practice guidelines for all the most commonly occurring disorders based on the best clinical evidence available. The practice guidelines (Diagnosis-based Treatment Guidelines and Level of Care Guidelines) were originally developed by VO-CHN – our Colorado contract. They have been developed for 26 levels of care and 30 diagnoses with the help of national experts, protocols from professional organizations, Clinical Advisory Committees, best practices standards, providers specifically for Medicaid enrollees, as well as our own expert clinical and medical staff. Additional sources for the guidelines have included resources such as the American Psychiatric Association Manual for Peer Review, the Diagnostic and Statistical Manual IV, Utilization Review Accreditation Commission Standards and various criteria sets from other utilization review firms and third party payers.

Diagnosis-based treatment guidelines are included in our Provider Manuals and are used by our Care Managers and Intensive Care Managers as they consider consumers' progress as part of concurrent reviews. In particular, Intensive Care Managers use the guidelines in recommending other treatment strategies if a high need consumer seems to be making less-than-optimum progress in treatment. Diagnosis-based treatment guidelines also are often used in clinical audits and quality management initiatives. In some Service Centers, consumers have developed corollaries to the Diagnosis-based treatment guidelines to help other consumers understand the array of interventions that have been proven effective for particular conditions or diagnoses.

5. ***Does your care management program include behavioral health conditions, if yes, where is it currently being used?***

Yes, ValueOptions care management program oversees behavioral health conditions and is currently used in all contracts as listed in the chart above.

6. ***Is the function for behavioral health care management fully performed within your organization or do you subcontract with another entity? If a subcontract arrangement is used, please fully describe such arrangements and how coordination across entities is ensured.***

ValueOptions fully performs behavioral health care management within our organization.

7. ***Please describe your care management approach to behavioral health conditions, addressing each of the above conditions specifically. Include in your description how you identify individuals in need of disease management interventions; your outreach and education approach; approach to co-morbid mental and physical conditions; the number of individuals served; your approach to provider behavior, including the use of clinical guidelines; staff qualifications; your experience and approach to managing within benefit limits; and a description of measurable outcomes resulting from the management intervention.***

ValueOptions' Care Management process includes, in addition to authorizing and reviewing services, responsibility to coordinate treatment planning and service delivery across programs and funding streams. Our Care Managers and our network providers are also responsible for collaborating with other professionals who also may be providing medical or social/educational services to an individual consumer. Encouraging compliance with best clinical practices and supporting consumers and providers in a recovery-oriented approach are key components of Care Management.

As our experience in public sector programs has grown, ValueOptions also has added an additional focus to its approach to Care Management: the use of data to allow us to focus the majority of our clinical efforts in serving:

- consumers with the most significant clinical needs;
- consumers (especially children and adolescents) at risk of requiring intensive levels of care; and
- providers whose clinical outcomes and practice patterns differ significantly from those of other providers of similar services.

ValueOptions provides varying intensities of Care Management in its public sector programs, and generally has Care Managers, Intensive Care Managers and Field Care Managers as part of the Clinical Departments in our public sector service centers.

Our focus is always to ensure that consumers receive appropriate, quality treatment and that those with the greatest needs receive the most assistance. In programs across the nation, ValueOptions has demonstrated that appropriate mental health treatment, easily accessed and promptly provided, ensures the best clinical outcomes and the most cost effective care.

Diagnosis-Related Treatment Guidelines

In addition for high risk recipients, ValueOptions uses Diagnosis-based treatment guidelines. As noted above, these guidelines were developed by ValueOptions with input from members and internal and external providers. They are used by the providers and the ValueOptions' Service Center clinical staff to further define and enhance the delivery of services to individuals with an array of mental health problems.

As part of our commitment to consumer involvement and leadership, ValueOptions has also developed and maintained consumer guidelines that mirror the clinical diagnosis based

guidelines. The consumer versions of the guidelines were written by consumers and advocates to assist members and the families of members who suffer from various diagnoses and clinical conditions.

G. Capitation Model

ValueOptions' experience in capitation models and our willingness to work in a risk environment is described in our response to *Question 3* above.

H. Data and Systems Capability

1. ***Please list and describe data, including encounter data, and reports you have experience producing for external monitoring. Please list those states for whom you provide this information.***

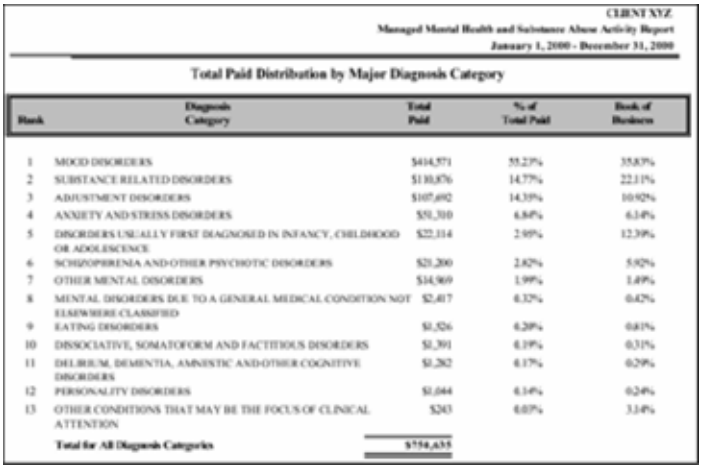
ValueOptions' Connections Administrative System includes reporting capabilities. The Data Warehouse System receives data imports from Connections Administrative System and other systems for reporting purposes. This data is formatted and stored as standard data into a relational database system. An advantage of this data warehousing technique is the easy insertion of data from external sources. Data from outside sources can be integrated into the data models to enhance reporting capabilities. These standard data models are used as the foundation for report generation, statistical analysis, decision support, and outcomes management. Reports generated from this data cover a wide range of functional areas including authorization, paid claims, membership, inquiry tracking, provider, and HEDIS®.

Every public sector contract includes its own reporting requirements, which cover both data and format. In addition, ValueOptions has created a standard package of reports, called FirstLight. Both customized and standard reports leverage our substantial investment in data warehousing technology as well as our migration to a single IS platform to provide better, more meaningful reporting to our clients. Because ValueOptions feels that the delivery method is just as important as the report itself, a significant portion of ValueOptions' intent in our reporting model is the transformation of data into useful and user-friendly information.

On the following page we provide sample report pages.

Examples of the type of information captured in FirstLight include:

- Normalized Levels of Care (allows for enterprise-wide reporting),
- Major Diagnostic groupings (allows for summarization and enterprise reporting),

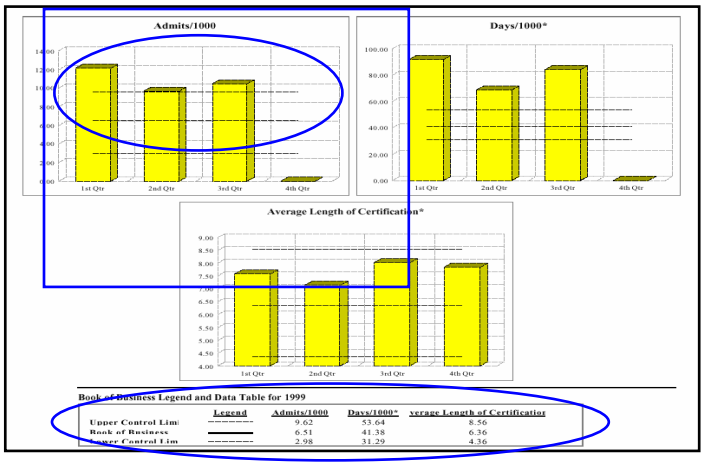


CLIENT XYZ
Managed Mental Health and Substance Abuse Activity Report
January 1, 2000 - December 31, 2000

Total Paid Distribution by Major Diagnosis Category

Rank	Diagnosis Category	Total Paid	% of Total Paid	Book of Business
1	MOOD DISORDERS	$414,571	55.23%	35.83%
2	SUBSTANCE RELATED DISORDERS	$130,876	14.77%	22.11%
3	ADJUSTMENT DISORDERS	$107,692	14.35%	10.92%
4	ANXIETY AND STRESS DISORDERS	$51,310	6.84%	6.14%
5	DISORDERS USUALLY FIRST DIAGNOSED IN INFANCY, CHILDHOOD OR ADOLESCENCE	$22,114	2.95%	12.39%
6	SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	$21,200	2.82%	5.92%
7	OTHER MENTAL DISORDERS	$14,969	1.99%	1.49%
8	MENTAL DISORDERS DUE TO A GENERAL MEDICAL CONDITION NOT ELSEWHERE CLASSIFIED	$2,417	0.32%	0.42%
9	EATING DISORDERS	$1,526	0.20%	0.01%
10	DISSOCIATIVE, SOMATOFORM AND FACTITIOUS DISORDERS	$1,391	0.19%	0.31%
11	DELIRIUM, DEMENTIA, AMNESTIC AND OTHER COGNITIVE DISORDERS	$1,282	0.17%	0.29%
12	PERSONALITY DISORDERS	$1,044	0.14%	0.24%
13	OTHER CONDITIONS THAT MAY BE THE FOCUS OF CLINICAL ATTENTION	$243	0.03%	3.14%
	Total for All Diagnosis Categories	**$750,635**		

- Membership information (provides for accurate per 1000 and per employee per month calculations),
- Book of Business Utilization Statistics, and



- Satisfaction Survey Information.

Our decision support system via the data warehouse contains more than 200 standardized reports that are used for operational management (e.g., MHSA and EAP utilization and case tracking) as well as client deliverables. Our reports are categorized by functional area including:

- Authorization - clinical utilization, outlier management and appeals,
- Paid claims - utilization, claim lags, claims processing and fraud & abuse,
- Membership - reports detailing enrollment including demographic data,
- Inquiry Tracking - reports detailing customer inquiries including complaints,

- Provider - reports tracking basis information on our provider networks, and
- HEDIS reports meeting NCQA standards.

The advantage of FirstLight is that it provides essential information to allow ValueOptions to monitor business operations. This effort translates into improved service to our clients, a better understanding for the client program effort, and the ability to provide clients with interventions should problems arise. FirstLight also leverages our data warehouse to provide outcomes reporting at a variety of depths, and to provide comparisons across our book of business and with industry norms. In addition, our capabilities allow a new account and/or service center to expect a full set of reports before "going live."

The following table contains descriptions of some standard reports ValueOptions is capable of producing.

Report Title	Report Description
Acute Inpatient and Alternative Levels of Care Utilization — Psychiatric vs. Substance Abuse	This report compares utilization data for Substance Abuse and Psychiatric services and levels of care. This report provides detail information as well as a summary.
Utilization Trends — Inpatient	This report identifies trends in utilization of the MHSA inpatient services.
Utilization Trends — Outpatient Certification Data	This report identifies trends in utilization of the MHSA outpatient services.
Recidivism Rates	This report compares Psychiatric recidivism rates to Substance Abuse recidivism rates. The comparison encompasses information including age range, number of hospitalizations for the previous year, and the number of readmissions over the course of time with a breakdown of 30 days, 90 days and 365 days.
Total Outpatient Utilization	This report identifies the authorizations made for outpatient services and shows number of visits, by quarter and with a year-end date.
Penetration Rate by Beneficiary Type	This report compares inpatient to outpatient penetration rates. It breaks down the information to the member, spouse, dependent and total penetration.
Paid Claim Analysis	This report compares claims payments between In-Network claims and Out-of-Network claims. This report allows for the client to see for what services claims have been paid and which of those claims were for services for In-Network providers versus Out-of-Network providers. This report also identifies the PEPM rate for each of the services.
Paid Claim Analysis	This report identifies reports paid for various age ranges and gender.
Network Savings	This report identifies services where ValueOptions has provided savings through using our provider network.
Total Paid Distribution by Major Diagnosis Category	This report identifies the total amount paid and the percentage of payments made per major diagnosis categories.
Total Paid Distribution by Provider Status	This report identifies the amounts paid and the percentage paid to In-Network and Out-of-Network claims.

2. ***Please describe how and what data you use to monitor, measure, and evaluate your performance, including the performance of your network providers and any subcontractors. Please be as specific as possible.***

Just as each program operated by ValueOptions Public Sector Division has unique reporting requirements, each program also has its own performance monitors and supporting data sets. At the request of the Bureau of TennCare, we can provide examples from current contracts. In general, we evaluate our own performance based on priorities established by each state or county (such as expanding access, expanding the array of services and supports, implementing evidence-based or emerging best practices) and technical requirements (such as claims turnaround time, speed of telephone answer, and resolution of complaints and grievances).

Provider profiling also is designed to meet the requirements of each individual delivery system. To demonstrate the variety between profiling strategies, we will include two programs: the PCC program in Massachusetts and profiles created for Pennsylvania counties with whom we contract and include this information as **Attachment 1**. We also have included examples of provider profiles in **Attachment 1** for inpatient, outpatient, rehabilitative services for children, and RTF.

In many public sector contracts, our state partners monitor our performance independently, based on data that we provide to them. The table that follows lists the actual data exchanges that ValueOptions has implemented and currently supports for clients in all lines of business, including public sector, health plan, and employer groups. Our data exchange experience not only includes the typical data exchanges in our industry, but also includes the client-specific, customized data exchanges as required by many of our public sector clients. All data exchange procedures include support software developed by ValueOptions with complete functionality such as error reporting, data cleansing, tracking, error correction, and performance metrics.

ValueOptions Data Exchange Transactions			
	Type Exchange	**Description**	**Direction**
1	Eligibility	Imports eligibility information into ValueOptions MHS membership database with add and change records. These transactions associate members with clients, groups, coverage tiers, and specific benefit plans. Member demographic information, client specific ID number, and primary care physician number is also included in this transaction. For some clients custom member-specific data fields are also populated into an adjunct MHS database.	Inbound
2	Eligibility Full	Imports member information as described above. This transaction is a full refresh or full population of the member eligibility information.	Inbound
3	Group Master Load	Imports Group information sometimes referred to as client-level eligibility information. Maintains client group numbers and creates MHS group number and cross reference table, if necessary.	Inbound
4	PCP Demographics	Imports Primary Care Practitioner (PCP) demographics information to populate the PCP table in the MHS database. Each member record can contain a PCP field that is cross-referenced to the MHS PCP table.	Inbound
5	Provider Network	Imports mental health provider information to populate MHS Provider	Inbound

ValueOptions Data Exchange Transactions			
	Type Exchange	**Description**	**Direction**
		Network tables. This transaction is used in programs where ValueOptions is contractually bound to use a non-ValueOptions or client provider network. Includes provider demographic information, clinical information necessary to conduct a referral, practice location information, billing location information, and sufficient data to facilitate claims payment.	
6	Provider Information	Exports the MHS provider information to be loaded into a client's target system. This export typically accompanies a paid claims export, item 11 below. Can include the client's provider number when that number is loaded into MHS.	Outbound
7	Accumulators	Imports the aggregate or combined physical health accumulators derived from paid medical/surgical claims, in the client's information system into the MHS database. This transaction is necessary to synchronize the mental health benefits paid by ValueOptions and the health care benefits paid by the client, when shared maximums apply, such as in the case of parity. This transaction is used when ValueOptions pays the mental health claims and the client pays the health care claims. This transaction must accompany transaction #8 below.	Inbound
8	Accumulators	Exports the aggregate mental health accumulators, derived from paid behavioral health claims, to the client's information system. When the client receives this transaction, the client adds the mental counters to the client's system. This transaction must accompany transaction #7 above.	Outbound
9	Authorizations	Exports authorizations for service approved by ValueOptions' Care Managers. This transaction is used when ValueOptions does not pay mental health claims for the client. The authorization transaction is sent to the client's claims payment system to support the claims processing function. It can include member ID, provider ID, level of care requested and approved, service class or service code, begin and end dates, frequency, and number of units.	Outbound
10	Paid Claims and Encounters	Exports claims payment information to the client. This transaction is used when ValueOptions pays the mental health claims for a client and the client requires a paid claims feed. A paid-claims feed can be at the detail level or ValueOptions can also provide aggregate transactions based on the client-specific requirement. The Provider Information transaction, number 6 above, typically accompanies this transaction. Data includes member ID, provider ID, date of service, service or revenue code, amount charged, allowed account, amount applied to deductible, co-pay or coinsurance, amount paid, paid date.	Outbound
11	Paid Claims and encounters	Imports claims paid by the client. This transaction is used when the client pays the mental health care claims and ValueOptions has a claims reporting requirement or if ValueOptions is in an "At Risk" agreement and the client pays claims. These transactions are typically imported directly into the MHS, into an externally paid claims table, held separately from MHS paid claims. This transaction is typically paired with the Authorization Export, number 9 above.	Inbound
12	Third Party Liability or Other	Imported and loaded into the MHS TPL/OHI database tables. This TPL/OHI information is referenced during the claims adjudication process to ensure	Inbound

ValueOptions Data Exchange Transactions			
	Type Exchange	**Description**	**Direction**
	Health Insurance	other liable insurance payers are the primary payer before ValueOptions disburses funds for claims payment. These records typically include information regarding the member, the subscriber, and the other insurance carrier.	

I. Net Worth and Restricted Deposit Requirements

1. Do you consider the net worth and depositing requirements to be a deterrent to contracting with TennCare? If so, please explain.

ValueOptions has the financial strength and is prepared to meet the equity reserves as outlined in the TennCare RFI. We would, however, request that the agency review the financial requirements in relationship to comparing a public sector program to a commercial program. Some of the considerations should be:

a) Unlike commercial projects, the state qualifies members for this program. In terms of equity reserve requirements, the managing entity cannot sell or bring other revenues to the program in the event of an equity issue.
b) Unlike commercial projects, the state essentially sets the rates for the program. The managing entity cannot raise premiums at will. Additionally, we would assume that the state has set rates at an actuarially sound level which would somewhat mitigate equity reserves based upon a traditional commercial product.
c) The state is in control of the premium dollars from the outset, assuming rates have been set at an actuarially sound level and considering the monthly reporting required by projects of this nature, the is minimal risk for a catastrophic amount of cash to be lost by the state.

J. Implementation Timeframe

1. Does the anticipated timeframe of an April 2006 contract award and an October 2006 implementation date impact your decision whether to participate in the program? If yes, how?

No, a six-month implementation period is standard for Medicaid managed behavioral health care programs.

In the design of a procurement and implementation process, a six-month implementation period is adequate to recruit, contract and credential a provider network. Requiring Letters of Commitment from providers who are submitting proposals may allow large providers to influence the procurement process by their willingness or unwillingness to sign a Letter of Commitment with one or more vendors. Requiring Letters of

Commitment also often offers a substantial benefit to incumbent contractors who already have a provider network in place. Instead we recommend that the TennCare Bureau establish incentives or penalties for the contracting of a provider network and assure equality among all competitors.

2. ***Do you have any suggestions or recommendations regarding the procurement and implementation timeframe? What is your recommended minimal and optimal timeframe between contract award and implementation?***

One of the unique value-added contributions ValueOptions offers is our experience implementing more Medicaid managed behavioral health programs than any other company in the country. We have a reputation for well-executed implementations in both our private and public sector divisions, having successfully implemented projects similar in scope and complexity to the TennCare program.